

Mental Health Adult Intake Form

Please complete all information, front and back of these forms and bring to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. This form is required for your initial intake appointment, so if it is not completed, you will be asked to fill it out in the lobby before seeing your provider. Thank you

Name _____ Date _____

Date of Birth _____ Primary Care Physician _____

Do you give permission for regular on-going updates to your primary care physician? _____

What are the problem(s) for which you are seeking help?

1. _____

2. _____

3. _____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms):

- | | | |
|---|---|---|
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Suspiciousness |
| <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Anxiety attacks | <input type="checkbox"/> Excessive guilt |
| <input type="checkbox"/> Increased risky behavior | <input type="checkbox"/> Avoidance | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Increased libido | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Crying spells |

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? () Yes () No.
If **YES**, please answer the following. If **NO**, please skip to the next section.

Do you **currently** feel that you don't want to live? () Yes () No
How often do you have these thoughts?

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

Have you had recent thoughts of suicide? _____

If Yes, do you have a plan? (please explain)

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

DEPRESSION SCREEN:

Over the last 2 weeks , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself---or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite---being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	_____	+	_____	+
			_____	+

How **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people? (*please circle one*)

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Anxiety Screen

Over the last 2 weeks , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Troubling relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	_____	+	_____	+
			_____	+

I have been exposed to actual or threatened death, serious injury or sexual violence. **Y N**

I have intense memories of a previous traumatic event. **Y N**

I try to avoid people, places or things associated with a traumatic event. **Y N**

My thoughts and moods have been negatively impacted by a traumatic event. **Y N**

I feel numb, detached or isolated from others. **Y N**

I have mood swings that seem to come out of nowhere. **Y N**

List ALL current prescription medications and how often you take them, (if none, write none)

<u>Medication:</u>	<u>Dose:</u>	<u>When Started:</u>

Current over-the-counter medications/supplements/vitamins:

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect?
() Yes () No;. Please describe when, where, and by whom:

Have you been exposed to Domestic Violence? _____

Legal History:

Have you ever been arrested? _____
Do you have any pending legal problems? _____

Past Psychiatric History:

Outpatient treatment () Yes () No; If yes, please describe below:

<u>Reason:</u>	<u>Dates:</u>	<u>Provider:</u>

Psychiatric Hospitalization: () Yes () No; If yes, describe below:

<u>Reason:</u>	<u>Date/Length of stay:</u>	<u>Hospital:</u>

Past Psychiatric Medications: If you have ever taken any of the following medications, please state if they were helpful, and any side affects you remember (it is ok if you do not remember all aspects, please fill in what you can).

	<u>WHEN:</u>	<u>DOSE:</u>	<u>RESPONSE/SIDE EFFECTS:</u>
<u>Antidepressants:</u>			
Prozac (fluoxetine)	_____		
Zoloft (sertraline)	_____		
Luvox (fluvoxamine)	_____		
Paxil (paroxetine)	_____		
Celexa (citalopram)	_____		

Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Other _____

Mood Stabilizers:

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Topamax (topiramate) _____
Other _____

Antipsychotics/Mood Stabilizers:

Abilify (aripiprazole) _____
Risperdal (risperidone) _____
Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Other _____

Sleep Medications:

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Other _____

WHEN:

DOSE:

RESPONSE/SIDE EFFECTS:

Antianxiety medications:

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____

Other _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

- Bipolar disorder () Yes () No
 - Schizophrenia () Yes () No
 - Depression () Yes () No
 - Post-traumatic stress () Yes () No
 - Anxiety () Yes () No
 - Alcohol abuse () Yes () No
 - Anger () Yes () No
 - Violence () Yes () No
 - Other substance abuse () Yes () No
 - Suicide () Yes () No
- If yes, who had each problem?

Substance Use:

- Do you think you may have a problem with alcohol or drug use? () Yes () No
- Have you ever been treated for alcohol or drug use or abuse? () Yes () No
- If yes, for which substances?

If yes, where were you treated and when?

Check if you have ever tried the following:

	-----Yes / No; If yes, how long and when did you last use?	
Cocaine	()	(); _____
Stimulants (pills)	()	(); _____
Heroin	()	(); _____
Methamphetamine	()	(); _____
Marijuana	()	(); _____
Pain killers (not as prescribed)	()	(); _____
Methadone	()	(); _____
Sleeping pills	()	(); _____
Alcohol	()	(); _____
Ecstasy	()	(); _____
Other _____		_____

***How many caffeinated beverages do you drink a day?** Coffee _____ Sodas _____ Tea _____
Energy Drinks? _____

How you ever smoked cigarettes? () Yes () No
Currently? () Yes () No How many packs per day on average? _____ How many years? _____
In the past? () Yes () No, how many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? () Yes () No, in the past? () Yes () No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Where did you grow up? _____

List your siblings and their ages:

Has anyone in your immediate family died?

Past Medical History:

Allergies _____ Current Weight _____ Height _____

Current medical problems:

Past medical problems, including surgeries and prolonged hospital stays:

Your Exercise Level: Do you exercise regularly? () Yes () No

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? () Yes () No. Are you planning to get pregnant in the near future? () Yes () No

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical History:

	<u>Yourself:</u>	<u>Family:</u>
Thyroid Disease _____	() _____	() _____
Anemia _____	() _____	() _____
Liver Disease _____	() _____	() _____
Chronic Fatigue _____	() _____	() _____
Kidney Disease _____	() _____	() _____
Diabetes _____	() _____	() _____

	<u>Yourself:</u>	<u>Family:</u>
Asthma/respiratory problems -----	() -----	() -----
Stomach or intestinal problems --	() -----	() -----
Cancer (type) _____	() -----	() -----
Fibromyalgia _____	() -----	() -----
Heart Disease _____	() -----	() -----
Epilepsy or seizures -----	() -----	() -----
Chronic Pain _____	() -----	() -----
High Cholesterol -----	() -----	() -----
High blood pressure -----	() -----	() -----
Head trauma _____	() _____	() _____
Liver problems _____	() _____	() _____
Other _____	() _____	() _____

Educational History: Highest Grade Completed? _____
Did you attend college? _____ Where? _____ Major? _____

Occupational History:

Are you currently: () Working () Student () Unemployed () Disabled () Retired
How long in present position? _____
What is/was your occupation? _____

Where do you work? _____
Have you ever served in the military? _____

Relationship History and Current Family:

Are you currently: () Married () Partnered () Divorced () Single () Widowed
How long? _____
If not married, are you currently in a relationship? () Yes () No; If yes, how long? _____
Are you sexually active? () Yes () No
How would you identify your sexual orientation?
() straight/heterosexual () lesbian/gay/homosexual () bisexual () transsexual
() unsure/questioning () asexual () other () prefer not to answer

What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____

Have you had any prior marriages? () Yes () No;. If so, how many? _____
Do you have children? () Yes () No; If yes, list ages and gender: _____

List everyone who currently lives with you: _____

Spiritual Life: Do you belong to a particular religion or spiritual group? () Yes () No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things: () more helpful () stressful

Other comments or concerns:

Signature _____ Date _____

Emergency Contact _____ Telephone # _____